

**GIRLS QUEST  
CAMPER HEALTH HISTORY FORM  
To be completed by Parent/Guardian**

*Information on this form is not part of the camper acceptance process but is gathered to assist us in identifying appropriate care.*

Camper's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age as of July 1<sup>st</sup>: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
                    Month Day Year

Home Address: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

If Parent/Guardian is not available in a medical emergency, the Camp should notify:

Name: \_\_\_\_\_ Relationship to my child: \_\_\_\_\_

Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

**INSURANCE INFORMATION: A copy of your child's up-dated Insurance and Prescription Drug Cards are REQUIRED.**

Name of Insured: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Group or Policy #: \_\_\_\_\_ Carrier Phone Number: \_\_\_\_\_

**IMPORTANT: The following must be completed for attendance at Camp Oh-Neh-Tah.**

**PARENT/GUARDIAN AUTHORIZATIONS**

**Permission for Camper to Carry and Use Sunscreen:** Campers are allowed to carry, keep and use sunscreen at camp as long as (1) the sunscreen is used for the purpose of avoiding overexposure to the sun and not for medical treatment of an injury or illness, and (2) the sunscreen is approved by the FDA for over-the-counter use. If camper is unable to physically apply sunscreen, unlicensed personnel when directed to do so by camper, may assist them.

**Permission for Camper to Carry and Use Insect Repellant:** Ticks carrying Lyme disease are throughout New York State. Campers are allowed to carry, keep and use insect repellants for the purpose of preventing insect bites/stings and ticks and not for medical treatment of an injury or illness. If camper is unable to physically apply insect repellent, unlicensed personnel when directed to do so by camper, may assist them.

**Authorization for Treatment and Camp Activities:** To the best of my knowledge, this Health History is correct and complete. The camper has permission to engage in all camp activities except as noted. I give permission to the camp to arrange for necessary related transportation for my child. I agree to the release to the camp of any records necessary for treatment, referral, billing or insurance purposes. This form may be photocopied for trips out of camp. I hereby give permission to the camp to provide routine health care and to seek emergency medical treatment including, but not limited to, ordering x-rays or routine tests. I give permission for the camp health care provider(s) to dispense prescription(s) and non-prescription medication(s) to my child which are (i) approved by a physician, (ii) brought with my child to camp and/or (iii) are indicated in standing orders approved by a physician.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment to my child, including, but not limited to, hospitalization. I understand that if my child must be treated for a medical occurrence, that the camp will not be responsible for the cost of such care. I acknowledge that I (or my health insurance company) will be responsible for the cost of such care.

**Authorization for Release:** In the event of an emergency where I cannot be reached or I am unable to pick up my child, I hereby give Girls Quest permission to release my child to the person named as the emergency contact.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

# HEALTH HISTORY

## To be completed by Parent/Guardian

Please provide complete information. Please notify us if there are any changes before your child starts camp.  
**PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD TO THE BACK PAGE OF THIS FORM**

### **ALLERGIES (List all known)**

Medication allergies (list)

Describe reaction and management of the reaction

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Food allergies (list)

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Other allergies (list- include insect stings, pollen, animals, asthma, etc.)

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### **RESTRICTIONS**

Dietary:       Does not eat red meat       Does not eat poultry       Does not eat pork  
                  Does not eat seafood       Does not eat eggs       Does not eat dairy products  
                  Other, please list \_\_\_\_\_

Activity:      Explain any physical limitation to activity \_\_\_\_\_  
                 \_\_\_\_\_

Behavioral, Emotional and Social Limitations: Has your child ever been diagnosed with and/or been treated for any of the following:  
 ADD or ADHD       Bipolar Disorder       PTSD  
 Anxiety       Conduct Disorder       Speech or language impairment  
 Autism spectrum disorder       Depression       Eating Disorder  
                 (PDD, Asperger's Syndrome)  
 Other \_\_\_\_\_

### **DISEASE HISTORY**

Which of the following illnesses has your child had?

Measles     Chicken Pox     German Measles     Mumps     Hepatitis     Varicella Zoster  
 Scarlet Fever

TB Mantoux Test    Date of Test: \_\_\_\_\_    Result:  Negative     Positive

**PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD TO THE BACK OF THIS FORM**

**GENERAL HEALTH**

Please respond with YES or NO to indicate if your child has or has experienced any of the following:

- \_\_\_ 1. Recent injury, illness or infectious disease
- \_\_\_ 2. Chronic or recurring illness/condition
- \_\_\_ 3. Been hospitalized
- \_\_\_ 4. Undergone surgery
- \_\_\_ 5. Frequent headaches
- \_\_\_ 6. Head injury or been knocked unconscious
- \_\_\_ 7. Wears glasses, contacts or protective eyewear
- \_\_\_ 8. Frequent ear infections
- \_\_\_ 9. Passed out during or after exercise
- \_\_\_ 10. Mononucleosis in the past 12 months
- \_\_\_ 11. Problems with diarrhea/constipation
- \_\_\_ 12. Begun menstruation
- \_\_\_ 13. Been told about menstruation
- \_\_\_ 14. Normal menstruation history
- \_\_\_ 15. Dizziness or chest pains during or after exercise
- \_\_\_ 16. Seizures
- \_\_\_ 17. High blood pressure
- \_\_\_ 18. Been diagnosed with a heart mummer
- \_\_\_ 19. Joint problems
- \_\_\_ 20. Skin problems, (e.g. itching, rash, acne)
- \_\_\_ 21. Diabetes
- \_\_\_ 22. Asthma
- \_\_\_ 23. Sickle Cell Trait
- \_\_\_ 24. Sickle Cell Anemia
- \_\_\_ 25. Tend to get respiratory infections

Please explain any "yes" answers to the above (identify #): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Chronic or recurring illnesses? \_\_\_\_\_  
\_\_\_\_\_

Operations or serious injuries (specify dates)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please record any other health-related information or issues not mentioned above: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD TO THE BACK OF THIS FORM, AS WELL AS A COPY OF YOUR CHILD'S MEDICAL AND HOSPITAL INSURANCE AND PRESCRIPTION DRUG CARDS.**

**For Camp Use Only**

Date Screened: _____	Time: _____ am/pm	Screened By: _____
Meds Received: _____		
Updated/additions to health history noted: ___Yes ___No ___None required		
Current health needs identified: _____		
Observation Notes: _____		
_____		
_____		

# MENINGOCOCCAL DISEASE LETTER

Dear Parent/Guardian,

I am writing to inform you about meningococcal disease, a potentially fatal bacterial infection commonly referred to as meningococcal meningitis. New York State Public Health Laws (NYSPL) SS2167 and Subpart 7-2 of the State Sanitary Code, requires overnight children's camps to distribute information about meningococcal disease and vaccination to all campers who attend camp for 7 or more consecutive nights.

Meningococcal disease is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. Meningococcal diseases can cause serious illness such as infection of the lining of the brain and spinal column (meningitis) or blood infections (sepsis). The disease strikes quickly and can lead to severe and permanent disabilities, such as hearing loss, brain damage, seizures, and limb amputation, in as many as one in five of those infected. Ten to 15 percent of those who get meningococcal disease will die.

Meningococcal disease can be easily spread from person-to-person by coughing, sharing beverages or eating utensils, kissing or spending time in close contact with someone who is sick or who carries the bacteria. People can spread the bacteria that cause meningococcal disease even before they know they are sick.

Anyone can get meningococcal disease, but certain people are at increased risk including teens and young adults 16-23 years old and those with certain medical conditions that affect the immune system.

The single best way to prevent meningococcal disease is to be vaccinated. The meningococcal ACWY (MenACWY) vaccine protects against four major strains of bacteria which cause meningococcal diseases in the United States. The Centers for Disease Control and Prevention (CDC) recommends a single dose of MenACWY at age 11 through 12 years with a booster dose given at age 16 years. Children are not routinely recommended to receive MenACWY vaccine prior to the recommended ages, unless they have certain underlying medical conditions which increase their risk of disease. The meningococcal B (MenB) vaccine protects against a fifth strain of meningococcal bacteria which causes meningococcal disease. Young adults aged 16 through 23 years may be vaccinated with MenB vaccine and should discuss the MenB vaccine with a healthcare provider.

I encourage you to review the [Meningococcal Disease Fact Sheet](http://www.health.ny.gov/publications/2168.pdf) available from the New York State Department of Health at <http://www.health.ny.gov/publications/2168.pdf>.

You can also find information about the disease at the website of the Centers for Disease Control and Prevention: [www.cdc.gov/vaccines/vpd-vac/mening/default.htm](http://www.cdc.gov/vaccines/vpd-vac/mening/default.htm).

Information about the availability and cost of meningococcal vaccine can be obtained from your healthcare provider or your local health department.

*Girls Quest* Camp Oh-Neh-Tah is required to maintain a record for each camper, signed by the camper's parent or guardian who documents the following:

- Receipt and review of meningococcal disease and vaccination information  
AND EITHER
- Certification that the camper has been immunized against meningococcal meningitis within the past 10 years; OR
- An understanding of meningococcal diseases risks and benefits of vaccination at the recommended ages and the decision not to obtain immunization against meningococcal meningitis at this time.

Please complete the [Meningococcal Meningitis Vaccination Response Form](#) which is a part of this **Camper Health History Form**.

Sincerely,

Connie Stine, Camp Director  
Girls Quest Camp Oh-Neh-Tah

# MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

## To be completed by Parent/Guardian

New York State Public Health Law requires that a parent or guardian of campers who attend an overnight children's camp for seven (7) or more consecutive nights, complete and return the following to the camp.

The Centers for Disease Control and Prevention recommends two doses of MenACWY vaccine (Brand names: Menactra, Menveo) for all healthy adolescents 11 through 18 years of age: the first dose is given at 11 or 12 years of age, with a booster dose at 16 years of age. Children and adolescents with certain medical conditions may need to begin the MenACWY series at a younger age and/or receive additional doses. Consult your child's health care provider regarding any medical conditions they may have.

If the first dose is given between 13 and 15 years of age, the booster should be given between 16 and 18 years of age. If the first dose is given after the 16<sup>th</sup> birthday, a booster is not needed.

Young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series (Brand names: Trumenba, Bexsero). Parents/guardians should discuss the Meningococcal B vaccine with a health care provider.

### Check Off, Fill In and Sign Below:

I have received and reviewed the information regarding Meningococcal Meningitis. My child has received Meningococcal immunization (Menactra or Menveo) within the past \_\_\_ years.  
Date Received: \_\_\_\_\_

### **OR**

I have received and reviewed the information regarding Meningococcal Meningitis. I understand the risks of Meningococcal Meningitis and the benefits of immunization at the recommended ages.

I have decided that my child who is **younger than 11 years of age**, will **not** obtain immunization against Meningococcal diseases at this time; or

I have decided that my child, who is **11 years of age or older**, will **not** obtain immunization against Meningococcal diseases at this time.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Camper's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Parent/Guardian Email Address (optional): \_\_\_\_\_

# GIRLS QUEST CAMPER PHYSICAL EXAM FORM

**To be completed by Doctor or qualified medical personnel**

Camper's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age as of July 1<sup>st</sup>: \_\_\_\_\_  
*Month Day Year*

**HEALTH EXAMINATION**

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BP: \_\_\_\_\_

This child is able to participate in a physically active program, including swimming.  Yes  No

Does this child have any restrictions, physical limitations, developmental or learning delays?  None (within normal limits)

Yes – Please select what type of limitation:  Physical  Cognitive  Behavioral/Language/Social/Emotional/Communication  
 Other

Please explain: \_\_\_\_\_

**ROUTINE MEDICATIONS PLEASE LIST ALL MEDICATIONS CURRENTLY AND ROUTINELY TAKEN (INCLUDING NON-PRESCRIPTION OR OVER-THE-COUNTER).**

This child does not take medications on a routine basis.

This child does take medication on a routine basis as follows:

Medication Name	Route	Dosage	Frequency	Diagnostic Comments

**OTHER AUTHORIZED MEDICATIONS:** The following medications are available in the camp Clinic and will be dispensed at the discretion of medical personnel, UNLESS otherwise noted by the child's healthcare provider. As the child's healthcare provider, you authorize that, (unless otherwise noted in "Remarks"), the medications listed below may be dispensed at the discretion of medical personnel at camp, per dosage, schedule and route indicated on the label.

Drug Name	Indications	Remarks
Tylenol (or generic acetaminophen)	Pain or fever	
Ibuprofen	Pain or fever	
Robitussin/Jr. (or generic)	Cough	
Chloraseptic (or generic)	Sore throat	
Pepto-Bismal (or generic)	Upset stomach	
Milk of Magnesia (or generic laxative)	Constipation	
Mucinex/Jr. (or generic)	Congestion	
Visine (or generic)	Eye redness/irritation	
Sudafed (or generic)	Nasal congestion/Eustachian tube congestion	
Claritin (or generic)	Nasal congestion/Eustachian tube congestion	
Benadryl (or generic diphenhydramine)	Allergic reactions (hives, insect bites)	
Antibiotic Ointment	Superficial cuts/abrasions	
Hydrocortisone Cream	Allergic reactions (contact dermatitis, insect bites)	
Calamine Lotion (or generic)	Allergic reactions (hives, insect bites)	

**DOCTOR'S SIGNATURE & STAMP**

I certify that the medical history of this child is correct and that the child has medical clearance to engage in all activities, except those noted on this form. In addition, I authorize that (unless otherwise noted in "Remarks" above) medications listed in the **Other Authorized Medications** section may be dispensed at the discretion of medical personnel at camp per dosage, schedule and route indicated on the label.

Doctor's Signature: \_\_\_\_\_ Date of Examination: \_\_\_\_\_ **DOCTOR'S STAMP**

# IMMUNIZATION HISTORY

## To be completed by Parent/Guardian

The New York State Department of Health requires a copy of the following information for every camper and staff member that attends our camp.

**PLEASE ATTACH A COPY OF YOUR CHILD'S IMMUNIZATION RECORD OR RECORD THE DATE/MONTH/YEAR OF BASIC IMMUNIZATIONS AND MOST RECENT BOOSTER DATES.**

Camper's Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age as of July 1<sup>st</sup>: \_\_\_\_\_  
*Month Day Year*

Vaccines	Year of Immunizations	Year of Last Booster
DTP	1. 2. 3.	1. 2.
TD (tetanus/diphtheria)		
Tetanus Booster		
Polio		
MMR		
Or Measles		
Or Mumps		
Or Rubella		
Hepatitis B		
Varicella (Chicken Pox)		
Meningococcal Meningitis		
TB Test		

# GIRLS QUEST Camp Oh-Neh-Tah

## CODE OF CONDUCT AGREEMENT

As a participant in the Girls Quest Camp Oh-Neh-Tah SEED Program, you will be exposed to many new experiences and live with a group of girls and mature adults. You will have the opportunity to explore your dreams, build independence and learn more about the world around you. To insure your health, safety and well-being, we expect you to adhere to the following rules and guidelines governing your behavior and participation in all activities.

Please initial *EACH* space, sign (print/signature) and date at the bottom along with your Parent or Guardian. Return to [Registrar@girlsquest.org](mailto:Registrar@girlsquest.org) OR Leandra Stewart, Girls Quest Registrar, PO Box 3190, NY, NY, 10163.

### AS A PARTICIPANT IN THE GIRLS QUEST CAMP OH-NEH-TAH SEED PROGRAM:

- \_\_\_\_\_ **I understand** that I am not allowed any personal technology or electronics for the duration of my stay at camp. This includes a phone, iPod, iPad, tablet, laptop, game console or any other form of technology.
- \_\_\_\_\_ **I will** respect the camp community, including my fellow campers, staff members and property, the natural world around me, and myself.
- \_\_\_\_\_ **I understand** that I must **ALWAYS** be with a staff member. I will not enter any cabin or building without a staff member. I am not allowed to wander away from my group for any reason at any time. I am not allowed at the waterfront without permission.
- \_\_\_\_\_ **I understand** that my Cabin Counselors are responsible for my health, safety and well-being at camp. I understand that I can talk to them about anything.
- \_\_\_\_\_ **I understand** that I will communicate in a respectful and appropriate way. I will not use bad, bullying, or abusive language. I will address issues by talking with my Counselors and I will try to resolve conflicts peacefully.
- \_\_\_\_\_ **I understand** that fighting or acting out physically with anybody at camp is grounds to be sent home at my parent's expense.
- \_\_\_\_\_ **I understand** I am a guest in a natural environment and will not pick-up, touch or taste anything without the expressed permission of a staff member. I will "leave nature alone".
- \_\_\_\_\_ **I understand** that I must be respectful and not tag or graffiti any camp property.
- \_\_\_\_\_ **I agree** as a sign of respect for the camp community, to participate in daily camp chores, keep my cabin clean and keep my belongings organized.
- \_\_\_\_\_ **I understand** that camp has a rugged terrain and I am required to wear closed-toed shoes (sneakers or boots) at all times except for daily trips to the shower facility.
- \_\_\_\_\_ **I understand** that I will have the opportunity to explore many new and different activities while at camp and I am expected to participate fully so I may benefit from the total camp experience.
- \_\_\_\_\_ **I understand** that I am expected to read and keep a journal daily.
- \_\_\_\_\_ **I understand** the camp day is extremely active and I will respect curfew (taps/lights out) to ensure I begin each day with energy and enthusiasm for the opportunities ahead.

\_\_\_\_\_  
SEED Participant Name (Print)

\_\_\_\_\_  
SEED Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date